STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	A. BUILDING 01			COMPLETED	
		155747	B. WIN			12/30/2011		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					ERCER AVE			
WOODCREST NURSING CENTER					UR, IN46733			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
K0000								
	A Life Safety Co	ode and	K(	0000				
	Environmental	Preoccupancy						
	Survey for the i	renovation of the B						
	Wing was cond	ucted by the						
	Indiana State D	•						
		dance with 42 CFR						
	483.70(a).	durice with 12 cm						
	465.70(a).							
	Sunvoy Dato: 1	2/20/11						
	Survey Date: 1	2/30/11						
	Facility Numbe							
	Provider Numb	er: 155747						
	AIM Number:	100290130						
	Surveyor: Amy	Kelley, Life Safety						
	Code Specialist							
	At this Life Safe	ety Code and						
	Environmental	·						
	<u>-</u>	rest Nursing Center						
		in compliance with						
	_ ·	for Participation in						
	Medicare/Medi	caid, 42 CFR						
	Subpart 483.70	O(a), Life Safety						
	From Fire and t	the 2000 edition of						
	the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and with 410 IAC							
		Invironment and						
		ards of the Indiana						
	Health Facilitie	s Rules for						
	I		- 1					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HXN721

Facility ID:

000556

If continuation sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 01		(X3) DATE SURVEY COMPLETED	
		155747	A. BU B. WI	ILDING NG			12/30/2011	
			B. WI		ADDRESS, CITY, STATI	E, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R			ERCER AVE	,		
WOODC	REST NURSING CI	ENTER			UR, IN46733			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED DEFICII	TO THE APPROPRIAT	E	COMPLETION DATE
1710		e care facilities. The		1710				DATE
	-	ing was surveyed						
		9, Existing Health						
	Care Occupanc	<del>-</del>						
	·							
	This one story							
		be of Type V (111)						
	construction ar							
		he facility has a fire						
	alarm system w							
	to the corridors	rridors, areas open						
		cility has a capacity						
		l a census of 116 at						
	the time of this							
		·						
		Robert Booher, Life Safety						
	Code Specialist-Me	dical Surveyor on 01/04/12.						
	The facility was	s found not in						
	compliance wit							
	aforementione							
	requirements a	s evidenced by the						
	following:							
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: H				1 Facility I	ID: 000556	If continuation sh	eet Pac	ge 2 of 6

		X1) PROVIDER/SUPPLIER/CLIA		JETIPLE COI	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		ENTIFICATION NUMBER: A. BUILD		BUILDING 01		COMPLETED		
155/4/		155747	B. WIN	3 <u> </u>		12/30/2	U11 	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE			
W0000		- 1750	1300 MERCER AVE					
WOODC	REST NURSING C	ENTER		DECAIL	JR, IN46733			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
K0056		natic sprinkler system, it is						
SS=D		installed in accordance with NFPA 13, Standard for the Installation of Sprinkler						
		le complete coverage for all						
		lding. The system is						
	' ' '	ed in accordance with NFPA						
		ne Inspection, Testing, and ater-Based Fire Protection						
		supervised. There is a						
		ate water supply for the						
		sprinkler systems are						
		er flow and tamper						
	the building fire ala	re electrically connected to arm system. 19.3.5						
	Based on obser	vation and	KO	056	K0056SS=D1. What correcti		01/27/2012	
	interview, the f	acility failed to			action(s) will be accomplishe those residents found to have			
	ensure complet	te automatic			been affected by the deficien			
	sprinkler syster	m was provided for			practice? In an effort to co			
	1 of 1 Rehabilit	ation storage			this deficient practice, sprinkl			
	rooms and 1 of	f 2 clean linen			heads and piping were order on January 6, 2011 from Allie			
	storage closets	in the remodeled B			Mechanical, Inc. The parts v			
	wing in accorda	ance with NFPA 13,			take about a week to come in			
	Standard for th	e Installation of			Allied Mechanical will install the parts arrive. (Rehab stor			
	Sprinkler Syste	ms, to provide			and clean linen storage areas			
	complete cover	age for all portions			How other residents having the			
	of the building.	. This deficient			potential to be affected by the			
	practice could a	affect any number			same deficient practice will be identified and what corrective			
	of staff.				action(s) will be taken? In			
	Findings includ	e:			effort to prevent residents from being affected by this deficient practice, the deficient practice will be corrected upon completion of			
	Based on an ob	servation with the			the automatic sprinkler syste			
	Director of Sup	port Services on			the remodeled B wing.3. What measures will be put into place			
	12/30/11 betw	veen 11:00 a.m. and						
	11:01 a.m., the	Rehabilitation			what systemic changes will be made to ensure that the defice			
	· ·	nd the clean linen			practice does not recur?	JIGHT		
					•			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HXN721 Facility ID:

000556

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFI		IDENTIFICATION NUMBER:	a. building 01			COMPLETED			
		155747	B. WIN		<del></del>	12/30/2011			
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	ROVIDER OR SUPPLIER	8			ERCER AVE				
WOODCREST NURSING CENTER			DECATUR, IN46733						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	storage closet	in the tub room			The deficient practice cannot				
	lacked sprinkle	er coverage. This			recur after the completion of automatic sprinkler system.4	•			
	was confirmed	by the Director of		How the corrective action(s)					
	Support Service	es at the time of							
	observations.			be monitored to ensure the deficient practice will not recur,					
					what quality assurance progr	ams			
	3.1-19(b)			will be put into place?  No monitoring needed.					
K0000									
	A Life Safety Co	ode and	K(	0000					
	Environmental								
	Survey for the I								
	Administration								
		he Indiana State							
	Department of								
	accordance wit	h 42 CFR 483.70(a).							
	Survey Date: 1	2/30/11							
	Facility Numbe	r: 000556							
	Provider Numb	er: 155747							
	AIM Number:	100290130							
	Surveyor: Amy	Kelley, Life Safety							
	Code Specialist	t							
	At this Life Safe	ety Code and							
	Environmental	Preoccupancy							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155747		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION  02		(X3) DATE SURVEY COMPLETED			
			A. BUII			<u> </u>		12/30/2011		
			B. WIN		DDDEGG CIEVI CELET	ZID CODE	, 00, 2	•		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
WOODCI	REST NURSING CI	ENTED			ERCER AVE UR, IN46733					
				<u> </u>	OIN, IN40733					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION		
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO	THE APPROPRIAT				
1710				1710				DATE		
	<del>-</del>	est Nursing Center								
		in compliance with								
	-	or Participation in								
	Medicare/Medi									
	Subpart 483.70	•								
		the 2000 edition of								
	the National Fir	re Protection								
	Association (NF	FPA) 101, Life Safety								
	Code (LSC), and	d with 410 IAC								
	16,2-3,1-19, E	Invironment and								
	Physical Standa	ırds of the Indiana								
	Health Facilities	s Rules for								
	Comprehensive care facilities. The									
	addition of the									
		addition including								
		pool, apartment,								
		and offices which								
		with Chapter 18,								
	-									
	New Health Car	re Occupancies.								
	<b>T</b> L'	Constitution of the consti								
	This one story	•								
		be of Type V (111)								
	construction ar	•								
		ne facility has a fire								
	alarm system w	vith smoke								
	detection in co	rridors, areas open								
	to the corridors	s and resident								
	rooms. The facility has a capacity of 143 and had a census of 116 at the time of this survey.									
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	<u> </u> HXN721	Facility I	D: <b>000556</b>	If continuation sl	neet Da	ge 5 of 6		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBE  155747			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING				(X3) DATE SURVEY COMPLETED 12/30/2011				
NAME OF P	ROVIDER OR SUPPLIER			_	ET ADDR	ESS, CITY, STAT	E, ZIP CODE				
	REST NURSING C			1300 MERCER AVE DECATUR, IN46733							
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENC ACH DEFICIENCY MUST BE PERCEDED I GULATORY OR LSC IDENTIFYING INFOR		ID PROVIDERS PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)				OULD BE COME			
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HXN721 Facility ID: 000556 If continuation sheet Page 6 of							ge 6 of 6				